MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1291 CERTIFICATE OF DEATH

Reg. Dist. No. 01288

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury, Md.
c. LENGTH OF STAY IN 1b: 2 yrs. 9 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rehobeth, Md. 19x-2
d. STREET ADDRESS: ---
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

091

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Bushard	B.	Adams	Jan	16	19 60

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	NEVER MARRIED [X]	Oct. 12, 1881	78 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	unk	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Richard Columbus Adams	Susan Rebeca Beale

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT	Address
No	---	None	Hospital Records	Salisbury, Md.

1

2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 15 min.
420.1
DUE TO
Conditions, if ony, which gove rise to immediate couse (o), stating the underlying couse last.
(b): Arteriosclerotic cardio vascular disease — years
DUE TO
(c): Arteriosclerosis generalized — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work [ ] Not while at work [ ]	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from Jan 1, 1958, to Jan 16, 1960, that I last saw the deceased alive on Jan 16, 1960, and that death occurred at 10:30 P.M, fram the causes and an the date stated abave.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: L. Maldve M.D.

PHYSICIAN'S NAME (Type): L. Maldve, M.D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL-(Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY	22d. LOCATION (City, town, or county) (State)
Burial	1-19-60	Rehobeth Baptist	Rehobeth, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Henry Watson	Pocomoke City, Md.	JAN 20 '60	Clinton S. Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1292 — Reg. Dist. No. 01289

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Few Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deers Head Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ernestine — Middle: Norma — Last: Baker

4. DATE OF DEATH: Month: 1 — Day: 5 — Year: 1960

5. SEX: f

6. COLOR OR RACE: C

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 24, 1935

9. AGE (In years last birthday): 24 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Hospital

11. BIRTHPLACE (State or foreign country): Talbot Co, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Roberts

14. MOTHER'S MAIDEN NAME: Leah Brummell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Gustina Roberts — Address: Trappe, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Phlebo thrombosis extremities — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO (c): Paraplegia transection of Cord T4 — INTERVAL BETWEEN ONSET AND DEATH: 2 3 Days

825 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☑ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Passenger auto accident -

20c. TIME OF INJURY: Hour: 1135 a.m. p.m. — Month, Day, Year: 12 13 1959

20d. INJURY OCCURRED: While at work ☐ Not while at work ☑

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Easton Hgts

20f. (City or town): Easton — (County): Talbot — (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED: 1-6-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/9/1960
22c. NAME OF CEMETERY OR CREMATORY: Trappe Cemetery
22d. LOCATION (City, town, or county): Trappe (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Herbert M Stillwell Jr. — ADDRESS: Cambridge Md

24a. REC'D BY REGISTRAR: DATE JAN 13 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Hurns

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1293 **CERTIFICATE OF DEATH** Reg. Dist. No. 01290

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 683 Fitzwater Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 683 Fitzwater Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First James Middle T. Last Collins

4. DATE OF DEATH: Month January Day 3 Year 1960

5. SEX: male

6. COLOR OR RACE: Col.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: July 10, 1865

9. AGE (In years last birthday): 94 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Collins

14. MOTHER'S MAIDEN NAME: Jane Martin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: George Collins, 408 Stewart Place Address Salisbury Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Mr James Collins,
DUE TO (b): Myocardial Heart Failure
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

782.4

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 15, 19 59, to Jan 3, 19 60, that I last saw the deceased alive on December 23, 19 59, and that death occurred at 5 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Carrie Hearn M.D. ADDRESS (Street, city or town, state): 226 N. Division St. Salisbury Md DATE SIGNED: 1/6/60

PHYSICIAN'S NAME (Type): Carrie Hearn MD 226 N. Division St Salisbury Md

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 1/5/ 1960

22c. NAME OF CEMETERY OR CREMATORY: church cemetery

22d. LOCATION (City, town, or county) (State): Snow Hill Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Clinton F. Stewart ADDRESS: Salisbury Md

24a. REC'D BY REGISTRAR DATE JAN 7 '60

24b. REGISTRAR'S SIGNATURE: Curtis S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01291

1294 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1590 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Royal Oak
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

091

3. NAME OF DECEASED (Type or print): First: Emma; Middle:; Last: Cook

4. DATE OF DEATH: Month: Jan. Day: 13 Year: 1960

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6/28/1868

9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Green

14. MOTHER'S MAIDEN NAME: Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Deer's Head Hospital Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic congestion of lung — INTERVAL BETWEEN ONSET AND DEATH: 5 days

422,1

Conditions, if any, which gove rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic cardiovascular disease — ?
DUE TO (c): Arteriosclerosis, general — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pyelonephritis, chronic

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Manth, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Nat while at work ☐

20e. PLACE OF INJURY (Home, farm, factary, street, affice bldg., etc.)

20f. (City or town) (County) (Stote)

21. I **certify** thot I attended the deceased from Sept. 6, 1955, to Jan. 13, 1960 that I last saw the deceased alive on January 13, 1960, and that death occurred at 10:45 P.M., from the causes and on the date stated abave.

ACTUAL SIGNATURE: V. Juerman M.D.
ADDRESS (Street, city or town, state): Deer's Head State Hospital
DATE SIGNED: 1/14/60

PHYSICIAN'S NAME (Type): V. Juerman, M. D.
Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/18/60
22c. NAME OF CEMETERY OR CREMATORY: Royal oak Cemtery
22d. LOCATION (City, town, or county): Royal oak (Stote): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James B. Oldfield
ADDRESS: Easton, Md.

24a. REC'D BY REGISTRAR DATE: JAN 28 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE

1296 CERTIFICATE OF DEATH

Female Colored

Baltimore, Maryland

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1295 CERTIFICATE OF DEATH

Reg. Dist. No. 01292

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY
c. LENGTH OF STAY IN 12
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
d. STREET ADDRESS 408 South Park Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Middle Last: Cooper
4. DATE OF DEATH Month: JANUARY Day: 31 Year: 1960

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JAN. 31, 1960
9. AGE (In years last birthday) yrs.: -
IF UNDER 1 YEAR Months: - Days: - IF UNDER 24 HRS. Hours: 6 Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: RUSSELL CARROLL COOPER
14. MOTHER'S MAIDEN NAME: PHYLLIS AMELIA MARSHALL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
INFORMANT Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH
762.5
DUE TO (b) Prematurity - Birth Wt - 2# 7oz
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Cerebral Anoxia

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
Atelectasis - Fetal Anoxia due to Placenta Previa
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/31, 1960, to 1/31, 1960 that I last saw the deceased alive on 1/31, 1960, and that death occurred at 2:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William C. Morgen M.D. ADDRESS (Street, city or town, state): Salisbury Md DATE SIGNED: 1/31/60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/1/60
22c. NAME OF CEMETERY OR CREMATORY: Shad Point Cem.
22d. LOCATION (City, town, or county) (State): Shad Point, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C. J. Messick ADDRESS: Bivalve, Md
24a. REC'D BY REGISTRAR DATE: FEB 2 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Travers

2082305XVI

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1295 CERTIFICATE OF DEATH

Reg. Dist. No. 01293

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 12
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ervin; Middle:; Last: CORNISH

4. DATE OF DEATH: Month: JANUARY; Day: 27; Year: 1960

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/20/1894

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Factory

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A.

13. FATHER'S NAME: Daniel Cornish

14. MOTHER'S MAIDEN NAME: Liza Byrd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Daniel Cornish Jr. Address: Eden Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): LOBAR PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 72 hrs.
DUE TO (b): METASTATIC CARCINOMA - GENERALIZED — —
DUE TO (c): CARCINIMA ESOPHAGUS - 1 yr.

150X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 26 JAN, 1960, to 29 JAN, 1960, that I last saw the deceased alive on JAN 27, 1960, and that death occurred at 1:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H. Gray Reeves M.D.
ADDRESS (Street, city or town, state): H. GRAY REEVES M.D. Medical Center, Salisbury, Md
DATE SIGNED:
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: I/31/60
22c. NAME OF CEMETERY OR CREMATORY: Mt Zion
22d. LOCATION (City, town, or county) (State): Polk Road, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: William H. James Jr. Princess Anne, Md

24a. REC'D BY REGISTRAR DATE: FEB 1 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1297 CERTIFICATE OF DEATH

01294

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City, 23x-2
d. STREET ADDRESS: R.F.D # 1 Box 208
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby Middle: Boy Last: Cottman

4. DATE OF DEATH: Month: January Day: 8 Year: 1960

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 8, 1960
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: 2 Min. 18

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY: Infant
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Collier
14. MOTHER'S MAIDEN NAME: Esther Cottman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): *-
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
INFORMANT: Jessie M. Cottman, Address: Pocomoke City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Immaturity (Birth wt 540 gms) — INTERVAL BETWEEN ONSET AND DEATH
776X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 8, 1960, to January 8, 1960, that I last saw the deceased alive on January 8, 1960, and that death occurred at 12 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Alfred C. Kolb M.D. ADDRESS (Street, city or town, state): Medical Center Salisbury, Maryland DATE SIGNED: 1/8/60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/8/59
22c. NAME OF CEMETERY OR CREMATORY: Tindley Chapel, Cem.
22d. LOCATION (City, town, or county) (State): Pocomoke City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar Wharton
ADDRESS: New Church, Va.
24a. REC'D BY REGISTRAR DATE: JAN 13 '60
24b. REGISTRAR'S SIGNATURE: Arthur B. Krantz

20821 82XV0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS/A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1298 CERTIFICATE OF DEATH

Reg. Dist. No. 01295

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 76 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wenona 19x-2
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Della; Middle; Last Dashiell

4. DATE OF DEATH: Month Jan. Day 12 Year 19 60

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: DEC 11-1876
9. AGE (In years lost birthday): 83 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Levin Collier
14. MOTHER'S MAIDEN NAME: Elizabeth Collier

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ?
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-01-5556 B
INFORMANT: Deer's Head Hospital Address Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ca. of pancreas with obstructive biliary cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: 5 mon.
DUE TO
157x
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 28, 19 59, to January 12, 19 60, that I last saw the deceased alive on January 12, 19 60, and that death occurred at 3:30 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. V. Maldve, M.D. — ADDRESS (Street, city or town, state): Deer's Head State Hospital — DATE SIGNED

PHYSICIAN'S NAME (Type): L. V. Maldve, M. D. — Salisbury, Maryland — 1/12/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: JAN 15-1960
22c. NAME OF CEMETERY OR CREMATORY: St. John's Methodist
22d. LOCATION (City, town, or county): Deal Island (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: L. D. Webster — ADDRESS: Deal Island Md.
24a. REC'D BY REGISTRAR DATE: JAN 21 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

Item 18 Film 254 1-22-60 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01296 Reg. Dist. No. 1299

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cor.N.Div.St & Main (Hearn Bldg.)

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: Hearn Bldg.(Apt.)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DOMENICO — Middle — Last DE LUCA
4. DATE OF DEATH: Month JAN. — Day 12th — Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov.26,1910
9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months 1 — Days 16
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shoe Maker-Employee
10b. KIND OF BUSINESS OR INDUSTRY: Shoe Repair
11. BIRTHPLACE (State or foreign country): Rome-Italy
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Nicola DeLuca
14. MOTHER'S MAIDEN NAME: Marie D'annibale

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Mary J. DeLuca (Wife) Address: 318 Ziegler Ave. Nazareth, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Dr. Earl L. Royer
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Jan. 14 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan.15,1960
22c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery-R.D.#
22d. LOCATION (City, town, or county) (State): Greensboro, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY — ADDRESS: SALISBURY MARYLAND
24a. REC'D BY REGISTRAR: DATE JAN 15 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1300

01297 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1005 W. Isabella St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 1005 W. Isabella St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LAURA — Middle E — Last DOVE

4. DATE OF DEATH: Month JAN. — Day 19th — Year 19 60

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 6, 1868

9. AGE (In years last birthday): 92 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Siloam, Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William Townsend

14. MOTHER'S MAIDEN NAME: Elizabeth V. Malone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

INFORMANT: Mr. Sewell H. Dove (Son) Address: Mt. Hermon Rd. R.D.# - Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.
DUE TO
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic Heart Disease — ?
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/1, 1960, to death, 19__, that I last saw the deceased alive on 1/15, 1960, and that death occurred at 5:00 A.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED: Jan. 19 1960

ACTUAL SIGNATURE: Ernest Larmore M.D.

PHYSICIAN'S NAME (Type): Dr. Ernest M. Larmore — Delmar, Delaware

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan. 21, 1960
22c. NAME OF CEMETERY OR CREMATORY: Siloam Cemetery
22d. LOCATION (City, town, or county) (State): Siloam, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY — ADDRESS: SALISBURY, MARYLAND

24a. REC'D BY REGISTRAR DATE: JAN 21 '60

24b. REGISTRAR'S SIGNATURE: Gilbert L. Truitt

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG254 1-18-60 et

1301

CERTIFICATE OF DEATH

01298

Reg. Dist. No.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 22 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: Delaware Street Extended
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Emory — Middle: Joshua — Last: Ellis

4. DATE OF DEATH: Month: January — Day: 5 — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/31/? Approx.

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Ellis

14. MOTHER'S MAIDEN NAME: Annie Jowns

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: None

INFORMANT: Deer's Head Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Uremia	?
DUE TO (b)	Glomerulonephritis	?
DUE TO (c)	Carcinoma of prostate gland	?

177X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic cardiovascular disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December 14 1959, to January 5, 1960, that I last saw the deceased alive on January 5, 1960, and that death occurred at 5:40 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: V. Juerman. M.D. — ADDRESS (Street, city or town, state): Deer's Head State Hospital — DATE SIGNED: 1/6/60

PHYSICIAN'S NAME (Type): V. Juerman, M. D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-10-60

22c. NAME OF CEMETERY OR CREMATORY: Green Acres Cem

22d. LOCATION (City, town, or county) (State): Salisbury Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Decker W. Elliott — ADDRESS

24a. REC'D BY REGISTRAR DATE: JAN 14 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Krouse

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01299

1302 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland
c. LENGTH OF STAY IN 1b 4mo. 22 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer'sHead State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury, Maryland
d. STREET ADDRESS 705 Parkway Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Laurena Middle Last Evans

4. DATE OF DEATH Month Jan Day 24 Year 19 60

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Feb. 18, 1877

9. AGE (In years last birthday) 82 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk

10b. KIND OF BUSINESS OR INDUSTRY unk

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles W. Goldsborough

14. MOTHER'S MAIDEN NAME Nancy M. Nelson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. unk

INFORMANT Hospital Records Address Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of super. mesenterial artery — INTERVAL BETWEEN ONSET AND DEATH 12 hrs.

450.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Arteriosclerosis general — Years

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Sept. 2, 1959 to Jan 24, 1960, that I last saw the deceased alive on Jan 24, 1960, and that death occurred at 9:00A M, from the causes and on the date stated above.

ACTUAL SIGNATURE V. Juerman M.D.

ADDRESS (Street, city or town, state) Salisbury, Maryland

DATE SIGNED Jan. 24, 1960

PHYSICIAN'S NAME (Type) V. Juerman, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF JAN-26-1960

22c. NAME OF CEMETERY OR CREMATORY NELSON'S CEMETERY

22d. LOCATION (City, town, or county) CRISFIELD (State) MD

23. FUNERAL DIRECTOR'S SIGNATURE Howard Crisfield ADDRESS

24a. REC'D BY REGISTRAR DATE JAN 29 '60

24b. REGISTRAR'S SIGNATURE Clifton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1303 CERTIFICATE OF DEATH

Reg. Dist. No. 01300

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 405 Naylor St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 1 405 Naylor St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HENRY — Middle FRED — Last FEDDERN

4. DATE OF DEATH: Month JANUARY — Day 25 — Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 30, 1895

9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months 11, Days 25 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carpenter - Construction

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: - - - - - - - - Feddern

14. MOTHER'S MAIDEN NAME: (No Record)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Mrs. Mae C Feddern (Wife) Address: 405 Naylor St Salisbury, Maryland

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Degenerative Heart Disease — 1955
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov, 1955 to Jan 25, 1960, that I last saw the deceased alive on Jan 21, 1960, and that death occurred at 6:30 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: William D Gray M.D. — ADDRESS (Street, city or town, state): Salisbury Md — DATE SIGNED: Jan. 26/1960

PHYSICIAN'S NAME (Type): Dr. William D.Gray — Camden Ave. Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan.28,1960

22c. NAME OF CEMETERY OR CREMATORY: O.U.A.M. Cemetery

22d. LOCATION (City, town, or county) (State): Millsboro, Delaware

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY - SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: JAN 29 '60

24b. REGISTRAR'S SIGNATURE: Curtiss L. Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG254 1-18-60 et

01301

CERTIFICATE OF DEATH

1304

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 082 PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X SHARPTOWN
d. STREET ADDRESS: RAILWAY & CEMETERY ST
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First GERONA Middle MORRIS Last FLETCHER

4. DATE OF DEATH: Month JANUARY Day 7 Year 60 19~~59~~

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: OCT 19, 1890
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED SEAMTRESS
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): LAUREL, DELAWARE
12. CITIZEN OF WHAT COUNTRY?: U S

13. FATHER'S NAME: JAMES MORRIS
14. MOTHER'S MAIDEN NAME: ELLEN DICKERSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-01-6539
INFORMANT: HOMER FLETCHER Address: SHARPTOWN, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 6 hours
DUE TO
420.1
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-6, 1960 to 1-7, 1960 that I last saw the deceased alive on 1-7, 1960, and that death occurred at 12 o'clock M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W R Ellis Jr M.D. ADDRESS (Street, city or town, state): Salisbury, Md. DATE SIGNED: 1-7-60

PHYSICIAN'S NAME (Type): W. R ELLIS

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: JAN 10, 1960
22c. NAME OF CEMETERY OR CREMATORY: FIREMEN'S
22d. LOCATION (City, town, or county) (State): SHARPTOWN, MD

23. FUNERAL DIRECTOR'S SIGNATURE: Paul J Smith ADDRESS: SHARPTOWN, MD
24a. REC'D BY REGISTRAR DATE: JAN 12 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01302
Reg. Dist. No.

1305

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne
d. STREET ADDRESS: Route # 1 Box 81
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Jacob Middle Last Gaines
4. DATE OF DEATH: Month 1- Day 31- Year 60 19

5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH:
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Perry Doome
14. MOTHER'S MAIDEN NAME: Matilda Wales

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-09-1166
17. INFORMANT: Mrs Matilda Gaines — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Sub-dural hemorrhage
824 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell from truck and was backed over.
20c. TIME OF INJURY: Hour 6 a. m. p. m. — Month, Day, Year: 12-16-59
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town) Princess Anne (County) Somerset (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2-2-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-5 60
22c. NAME OF CEMETERY OR CREMATORY: Chance Cem
22d. LOCATION (City, town, or county) (State): Chance Md

23. FUNERAL DIRECTOR'S SIGNATURE: Booker McWash
ADDRESS:
24a. REC'D BY REGISTRAR DATE: FEB 9 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Towne

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1306 CERTIFICATE OF DEATH

Reg. Dist. No. 01303

1. PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury, Maryland

c. LENGTH OF STAY IN 1b: 8mo. 26 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X R 2 Parsonsburg, Maryland

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

d. STREET ADDRESS: 1

e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First Isiah; Middle; Last Gordy

4. DATE OF DEATH: Month Jan; Day 10; Year 19 60

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 17, 1888

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months; Days — IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unk

10b. KIND OF BUSINESS OR INDUSTRY: unk

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Westly Gordy

14. MOTHER'S MAIDEN NAME: Nancy Gordy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unk (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: unk

INFORMANT: Hospital Records Address: Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Recurrent Cerebral Thrombosis w/rt. Hemiplegy — INTERVAL BETWEEN ONSET AND DEATH: 5d.

332 X

DUE TO (b): Arteriosclerosis general — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Carcinoma of prostate gland

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Apr. 15, 1959, to Jan 10, 1960, that I last saw the deceased alive on Jan 10, 1960, and that death occurred at 7:40A M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE V. Juerman M.D.

PHYSICIAN'S NAME (Type) V. Juerman, M.D. Salisbury, Maryland Jan. 10, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 1/16/1960

22c. NAME OF CEMETERY OR CREMATORY: glassco Cemetery

22d. LOCATION (City, town, or county) (State): Parsonsburg Md

23. FUNERAL DIRECTOR'S SIGNATURE: Clinton F. Stewart ADDRESS: Salis, Md.

24a. REC'D BY REGISTRAR DATE: JAN 15 '60

24b. REGISTRAR'S SIGNATURE: Clinton F. Stewart

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1307 Item#9-FilmG254-1/15/60-mb

Reg. Dist. No. 01304

1. PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b 7 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer Island State Hosp.
e. STREET ADDRESS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. — b. COUNTY Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Fairmount 19x-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

091

3. NAME OF DECEASED (Type or print) First Annie Middle L. Last Hopkins

4. DATE OF DEATH Month 1 Day 4 Year 1960

5. SEX F — 6. COLOR OR RACE W — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH 3-31-1841 — 9. AGE (In years last birthday) 88 yrs. 78

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None — 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country) Maryland — 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Williams Halland — 14. MOTHER'S MAIDEN NAME Mary W. Crasweld

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT Address Mary Horner Pr. Anne Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Paralytic Ileus — INTERVAL BETWEEN ONSET AND DEATH

904.7

DUE TO (b) Fracture Rt. hip. —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — Generalized Arteriosclerosis - Hypostatic Pneumonia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell to floor Deer Island Hosp.

20c. TIME OF INJURY (Hour) 8:45 a. m. p. m. — Month, Day, Year 1 3 1960

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital

20f. (City or town) Salisbury (County) Wicomico (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Earl L. Royer M.D.

EXAMINER'S NAME (Type) Earl L. Royer

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED 1-4-60

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 22b. DATE THEREOF 1-6-60 — 22c. NAME OF CEMETERY OR CREMATORY Fairmount Cem. — 22d. LOCATION (City, town, or county) Fairmount (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Jesse R. Wilson — ADDRESS Princess Anne Md

24a. REC'D BY REGISTRAR DATE JAN 11 '60 — 24b. REGISTRAR'S SIGNATURE Arthur S. Krebs

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1308 — 01305 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 082 Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Quantico
d. STREET ADDRESS: Route # 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Jesse — Middle: — Last: Hull
4. DATE OF DEATH: Month: 1-5-60 — Day — Year: 19

5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 9-5-94
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Educational
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John Hull
14. MOTHER'S MAIDEN NAME: Irene Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT — Address: Mrs. Winefred Dutton R F D # 2 Quantico

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 550.1 Generalized peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Ruptured appendix — 2 days
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L Royer M.D. — DATE SIGNED
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Earl L. Royer, M.D. — DEPUTY MEDICAL EXAMINER ☒ — 1-9-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-9-60
22c. NAME OF CEMETERY OR CREMATORY: Hall Cem.
22d. LOCATION (City, town, or county) (State): Weptawin, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Thornton B. Jolley, Salisbury Md.
24a. REC'D BY REGISTRAR — DATE: JAN 15 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01306

1309 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 601 DeCatur

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 1 601 DeCatur
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LUCY — Middle — Last HUMES

4. DATE OF DEATH: Month JANUARY — Day 22 — Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec.11,1898

9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months 1 Days 11 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Mardela, Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: James Graham

14. MOTHER'S MAIDEN NAME: Martha - - - - -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

INFORMANT: Mrs. Pauline Moore (Daughter) Address: R.D.#3 Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebro-Vascular Accident.

DUE TO (b): Hypertension.

DUE TO (c): Arteriosclerosis.

331x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 1958, to August, 1959, that I last saw the deceased alive on August, 1959, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Carrie Hearn M.D. ADDRESS (Street, city or town, state): 226 N. Division St DATE SIGNED: Jan. 29 /1960

PHYSICIAN'S NAME (Type): Dr. Carrie I. Hearn — North Division St Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan.28 /1960

22c. NAME OF CEMETERY OR CREMATORY: Spring Grove Cemetery

22d. LOCATION (City, town, or county) (State): R.D.# Mardela, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY — ADDRESS: SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: JAN 29 '60

24b. REGISTRAR'S SIGNATURE: Catina S. Timms

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1310 **CERTIFICATE OF DEATH** Reg. Dist. No. 01307

M

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 3 Mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springhill Sanitarium, Inc.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin 23x-2
d. STREET ADDRESS: 12 Baker St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

090

3. NAME OF DECEASED (Type or print): First Mrs. Middle Maude BOUNDS Last Humphreys

4. DATE OF DEATH: Month Jan. Day 2, Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 22, 1883
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): Somerset Co (RD)
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

I

13. FATHER'S NAME: EDWARD BOUNDS
14. MOTHER'S MAIDEN NAME: EMILY PUSEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: No
INFORMANT: Miss Mary Humphreys Address: Berlin Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1) Cerebral Thrombosis, multiple — INTERVAL BETWEEN ONSET AND DEATH: 4 mos.
332x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
(b)
DUE TO
(c) Arteriosclerosis, Generalized — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 1) Bronchiectasis 2) Pneumonitis, recurrent.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/24 19 69 to 1-2-60 19___, that I last saw the deceased alive on 1-2-60 19___, and that death occurred at 10:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Rufus S. Gardner, Jr. M.D.
ADDRESS (Street, city or town, state): Salisbury Bvld. and Pine Bluff Rd. Salisbury, Md.
DATE SIGNED
PHYSICIAN'S NAME (Type): Rufus S. Gardner. Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 1/5/59
22c. NAME OF CEMETERY OR ~~CREMATORY~~: BUCKINGHAM
22d. LOCATION (City, town, or county) (State): BERLIN MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Amos A. Burbage ADDRESS: Berlin Md
24a. REC'D BY REGISTRAR DATE: JAN 7 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Knauf

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01308

CERTIFICATE OF DEATH

1311 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 Wk
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hebron
d. STREET ADDRESS: Rt # 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First MARY Middle ANNE Last INSCOE
4. DATE OF DEATH: Month 1 Day 22 Year 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Sept 16,1915
9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sr. Nurses Aid
10b. KIND OF BUSINESS OR INDUSTRY: Hospital
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Ruffin Collie
14. MOTHER'S MAIDEN NAME: Mary Annie Powell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 243-20-3898
17. INFORMANT: Mr. Curtis Inscoe, Hebron, Md. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Subarachnoid hemorrhage. (2) — INTERVAL BETWEEN ONSET AND DEATH: 8 days
330X
DUE TO (b): Severe hypertension — Years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/23/ 1958 to 1/22/ 1960 that I last saw the deceased alive on 1/22/ 1960, and that death occurred at 2.25 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: O. J. Burton M.D. — ADDRESS (Street, city or town, state): 211 Maryland Ave. Salisbury, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): O. J. Burton, M.D. — 1/25/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-24-60
22c. NAME OF CEMETERY OR CREMATORY: Mardela Cemetery
22d. LOCATION (City, town, or county) (State): Mardela , Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hill & Johnson Co. Salisbury, MAryland
24a. REC'D BY REGISTRAR DATE: JAN 27 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

Norman T. Baker

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1312 CERTIFICATE OF DEATH

Reg. Dist. No. 01309

M

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 90 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown 1437.2
d. STREET ADDRESS: 411 Calvert Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

091

I

3. NAME OF DECEASED (Type or print): First: Bertha — Middle: — Last: Johnson

4. DATE OF DEATH: Month: 1 — Day: 24 — Year: 19 60

5. SEX: F

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-2-01

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): --

10b. KIND OF BUSINESS OR INDUSTRY: domestic

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John White

14. MOTHER'S MAIDEN NAME: Annie Frisbee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unk. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Deer's Head Records Address: Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypostatic congestion of lung — INTERVAL BETWEEN ONSET AND DEATH: 12 days

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive arteriosclerotic cardiovascular disease, decompensated. — Years

DUE TO (c): Arteriosclerosis, general — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Recurrent cerebral thrombosis and pyelonephritis, chronic.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-26, 1959, to 1-24-, 1960, that I last saw the deceased alive on 1-24, 1960, and that death occurred at 8:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: V. Juerman M.D.
ADDRESS (Street, city or town, state): Deer's Head State Hospital
DATE SIGNED: 1-25-60

PHYSICIAN'S NAME (Type): V. Juerman, M. D. Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/28/60
22c. NAME OF CEMETERY OR CREMATORY: Still Pond (col) Cem.
22d. LOCATION (City, town, or county) (State): Still Pond, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Walker
ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: JAN 28 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1313 CERTIFICATE OF DEATH

Reg. Dist. No. 01310

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 147 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hurlock 09x-2
d. STREET ADDRESS: Box 130½, Rt. #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Lucy; Middle: ; Last: Johnson

4. DATE OF DEATH: Month: 1; Day: 13; Year: 1960

5. SEX: F

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10-25-1900

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10b. KIND OF BUSINESS OR INDUSTRY: factories

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Henry

14. MOTHER'S MAIDEN NAME: Henrietta Robinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unk. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Deer's Head Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: ?
422.1
DUE TO (b): Arteriosclerosis, general — ?
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I ottended the deceosed from 8-19, 1959, to 1-13, 1960, thot I lost sow the deceosed olive on 1-13, 19 60, ond that death occurred at 5:50a M, from the couses ond on the dote stated above.

ACTUAL SIGNATURE: V. Juerman M.D.

ADDRESS (Street, city or town, stote): Deer's Head State Hospital, Salisbury, Maryland

DATE SIGNED: 1-13-60

PHYSICIAN'S NAME (Type): V. Juerman, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 1-15-60

22c. NAME OF CEMETERY OR CREMATORY: U. of Md. Med. School

22d. LOCATION (City, town, or county) (Stote): Balto. Med.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR DATE: FEB 2 '60

24b. REGISTRAR'S SIGNATURE: Curtis L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1342 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01311

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharptown
c. LENGTH OF STAY IN 1b: 5 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD — b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL - SHARPTOWN, MD
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ~~SETH~~ SALLIE — Middle NMI — Last Johnson
4. DATE OF DEATH: Month 1 — Day 26 — Year 1960
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JAN 2-1890
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): DELAWARE
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: PHILLIP SATCHELL
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Address: FRANCIS JOHNSON, LAUREL, DELAWARE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute enteritis
INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO
571.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I take charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 1-27-60

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 1/29/60
22c. NAME OF CEMETERY OR CREMATORY: CAREY'S CHURCH
22d. LOCATION (City, town, or county) (State): MILSBORO, DELAWARE

23. FUNERAL DIRECTOR'S SIGNATURE: Paul J. Smith — ADDRESS: Main St. Sharptown Md
24a. REC'D BY REGISTRAR DATE: FEB 1 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01312

CERTIFICATE OF DEATH

1314

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1638 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown, Md.
d. STREET ADDRESS: Quaker Neck, R.F.D.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

14X-2

091

3. NAME OF DECEASED (Type or print): First: Samuel — Middle: T. — Last: Kennard

4. DATE OF DEATH: Month: 1 — Day: 12 — Year: 1960

5. SEX: M

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-1-90

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Various

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Kennard

14. MOTHER'S MAIDEN NAME: Ellen Houston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unknown
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-03-2986

INFORMANT: Deer's Head Records — Address: Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hyperstatic congestion of lungs — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs.

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic cardiovascular disease
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Recurrent cerebral thrombosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that attended the deceased from 7-18, 1955, to 1-12, 1960, that I last saw the deceased alive on 1-12, 1960, and that death occurred at 5:50 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. V. Maldve M.D. — ADDRESS (Street, city or town, state): Deer's Head State Hospital — DATE SIGNED: 1-13-60

PHYSICIAN'S NAME (Type): L. V. Maldve, M.D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan. 16, 1960

22c. NAME OF CEMETERY OR CREMATORY: Pomona (col) Cem.

22d. LOCATION (City, town, or county) (State): Nr. Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Walley — ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: JAN 18 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1315

Reg. Dist. No. 01313

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 Month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pittsville Rural #1
d. STREET ADDRESS: 23X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Etta — Middle: D. — Last: Lewis

4. DATE OF DEATH: Month: January — Day: 30 — Year: 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 3 1886
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baywoman
10b. KIND OF BUSINESS OR INDUSTRY: Fishing and Bay
11. BIRTHPLACE (State or foreign country): Chincoteague, Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Daniel Lewis
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-28-4491
INFORMANT: Mrs. Ethel V. Lewis — Address: Pittsville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 20 days
DUE TO (b): Pyelonephritis, Right — 90 days
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
600.0
Rural #1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-2-60, 19__, to 1-30-60, 19__, that I last saw the deceased alive on Jan 30th, 1960, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Raymond M. Gow M.D. — ADDRESS (Street, city or town, state): 707 Camden Ave Salisbury Md — DATE SIGNED: 1-31-60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Feb 3/60 — 22c. NAME OF CEMETERY OR CREMATORY: Baptist Cemetery — 22d. LOCATION (City, town, or county) (State): Pittsville Md

23. FUNERAL DIRECTOR'S SIGNATURE: Elley Dennis — ADDRESS: Snowhill Md

24a. REC'D BY REGISTRAR DATE FEB 2 '60 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1343 CERTIFICATE OF DEATH

Reg. Dist. No. 01314

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.D.# 1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Salisbury
d. STREET ADDRESS: R.D.# 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ANTIONETTE (NETTIE) Middle Last LIVINGSTON

4. DATE OF DEATH: Month JAN. Day 12th Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Apr. 20, 1876
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): R.D.# 1 Salisbury, Md
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Anthony George Brown
14. MOTHER'S MAIDEN NAME: Mary Malone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
INFORMANT: Mr Lee R.Livingston(Husband) Address: R.D.# 1 Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Heart FAILURE	?
420.1 DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Chronic Coronary Insufficiency	6 mos.
DUE TO (c)	Generalized arteriosclerotic disease	10-15 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	Chronic malnutrition	

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 20, 1959, to January 12, 1960, that I last saw the deceased alive on December 31, 1959, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert J Adkins M.D.
ADDRESS (Street, city or town, state): Fruitland, Maryland
DATE SIGNED: Jan. 12 /1960
PHYSICIAN'S NAME (Type): Dr. Robert Adkins

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan.14,1960
22c. NAME OF CEMETERY OR CREMATORY: Union Cemetery - R.D.# Salisbury, Maryland
22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY
ADDRESS: SALISBURY MARYLAND
24a. REC'D BY REGISTRAR DATE: JAN 15 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01315

1344 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mardela
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Upper Bridge St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mardela
d. STREET ADDRESS: Upper Bridge St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle PATRICK Last MAC KENZIE

4. DATE OF DEATH: Month JANUARY Day 25th Year 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 17, 1865

9. AGE (In years last birthday): 94 yrs.
IF UNDER 1 YEAR: Months 10 Days 8
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Weaver- Retired Employee

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Ralph MacKenzie

14. MOTHER'S MAIDEN NAME: Mary Higgins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Mrs. Alice Maurry (Daughter) Address: Bridge St Mardela, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
DUE TO (b): Ulcer Stomach — 5 years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

540.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/25, 1960, to 1/25, 1960, that I last saw the deceased alive on 1/25, 1960, and that death occurred at 2:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H S Kuhlman M.D.

ADDRESS (Street, city or town, state): Sharptown, Maryland

DATE SIGNED: Jan. 29/1960

PHYSICIAN'S NAME (Type): Dr. H.S.Kuhlman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb.1,1960

22c. NAME OF CEMETERY OR CREMATORY: Holy Sepulchre Cemetery-Philadelphia, Pa.

22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: FEB 1 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1316

Reg. Dist. No. 01316

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 SALISBURY
d. STREET ADDRESS: REGENCY DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ALICE Middle Last MACMILLAN

4. DATE OF DEATH: Month JANUARY Day 24 Year 1960

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 24, 1944
9. AGE (In years last birthday): 15 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): NEW YORK
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALFRED R. MAC MILLAN
14. MOTHER'S MAIDEN NAME: OLGA FERNANDEZ

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: NONE
INFORMANT: ALFRED R. MACMILLAN Address: REGENCY Dr. SALISBURY, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Schilder's Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 years
DUE TO
355x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-8, 1960, to 1-24, 1960 that I last saw the deceased alive on 1-24, 1960, and that death occurred at 3 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Willem A. Ellis Jr. M.D. ADDRESS (Street, city or town, state): Salisbury, Md. DATE SIGNED: 1-27-60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): 1/26/1960
22b. DATE THEREOF: BURIAL
22c. NAME OF CEMETERY OR CREMATORY: Wicomico Mem. Park
22d. LOCATION (City, town, or county) (State): SALISBURY Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Thomas F. Wallace ADDRESS: Salisbury, Md.
24a. REC'D BY REGISTRAR DATE: JAN 27 '60
24b. REGISTRAR'S SIGNATURE: Orchard S. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG256 2-19-60 et

1317

CERTIFICATE OF DEATH

Reg. Dist. No. 01317

1. **PLACE OF DEATH**
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): STOCKTON, Md 23x-3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First JAMES — Middle A. — Last MARSHALL

4. **DATE OF DEATH**: Month JANUARY — Day 24 — Year 1960

5. SEX: MALE
6. COLOR OR RACE: NEGRO
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JULY 8, 1878
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10b. KIND OF BUSINESS OR INDUSTRY: OYSTERMAN
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN MARSHALL
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
INFORMANT: Address: Reuban Marshall — Stockton, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH:
420.1
DUE TO (b): Arteriosclerosis & Benign prostatic hypertrophy — 1 wk
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from 1-9, 1960, to 1-24, 1960 that I last saw the deceased alive on _____, 19____, and that death occurred at 1:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William H. Fitch Jr. M.D. ADDRESS (Street, city or town, state): Salisbury DATE SIGNED: Jan 25-60
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-28-60
22c. NAME OF CEMETERY OR CREMATORY: FORMAN
22d. LOCATION (City, town, or county) (State): Stockton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar Wharton — ADDRESS: Newcomb, Va.
24a. REC'D BY REGISTRAR DATE: FEB 2 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1318 **CERTIFICATE OF DEATH** 01318

Reg. Dist. No.

1. **PLACE OF DEATH**
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): STOCKTON, Md. 23x-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First OSCAR — Middle H. — Last MASON

4. **DATE OF DEATH**: Month JANUARY — Day 29 — Year 1960

5. SEX: MALE

6. COLOR OR RACE: COLORED

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: NOV. 12, 1915

9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: FACTORY-WORK

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: SAMUEL MASON

14. MOTHER'S MAIDEN NAME: LOUISE BAINE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Lavinia T. Mason — Address: Pocomoke, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from JANUARY 25, 1960, to JANUARY 29, 1960, that I last saw the deceased alive on JANUARY 29, 1960, and that death occurred at 7 A.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: David J. Gelman M.D.

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-2-60

22c. NAME OF CEMETERY OR CREMATORY: St. Paul

22d. LOCATION (City, town, or county) (State): Stockton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar W. Fraxton — ADDRESS: New Church, Va.

24a. REC'D BY REGISTRAR DATE: FEB 5 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01319

1319 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. **PLACE OF DEATH**
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Salisbury (Rural)
d. STREET ADDRESS: 1 R.D.# 3 (Mt Hermon Rd)
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First JAMES — Middle EDWARD — Last MATTHEWS

4. **DATE OF DEATH**: Month JANUARY — Day 29 — Year 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Oct. 6, 1890

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months 3 Days 23 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Poultry Business Owner

10b. KIND OF BUSINESS OR INDUSTRY: Chickens

11. BIRTHPLACE (State or foreign country): R.D.# Salisbury, Md

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Jackson J. Matthews

14. MOTHER'S MAIDEN NAME: Sally M. Parsons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

INFORMANT (Address): Mrs. Alice M. Matthews (Wife) R.D.# 3 Mt. Hermon Rd Salisbury, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarct, acute — INTERVAL BETWEEN ONSET AND DEATH: 4 days
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 1-25, 1960 to 1-29, 1960 that I last saw the deceased alive on 1-29, 1960, and that death occurred at 3:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wilber R. Ellis Jr M.D. — ADDRESS (Street, city or town, state): Salisbury, Md. — DATE SIGNED: 1-29-60

PHYSICIAN'S NAME (Type): Dr. Wilber R. Ellis Jr Medical Center Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan. 31, 1960

22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park

22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY — ADDRESS: SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: FEB 1 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01320

1320 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 1 303 S. Park Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James — Middle Walter — Last Mears

4. DATE OF DEATH: Month January — Day 3 — Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-7-99

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George R. Mears

14. MOTHER'S MAIDEN NAME: Laura F. Watson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unknown
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Deer's Head Records
Address: Mrs. Mary E. Mears (wife) 303 S. Park Dr. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 163X Carcinoma of Right Lung — INTERVAL BETWEEN ONSET AND DEATH: 7 yrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 2 Carcinoma of transverse colon

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-21, 1959, to 1-3, 1960, that I last saw the deceased alive on 1-3, 1960, and that death occurred at 10a.M, from the causes and an the date stated above.

ACTUAL SIGNATURE: L. V. Maldve M.D.
ADDRESS (Street, city or town, state): Deer's Head State Hospital
DATE SIGNED: 1-4-60

PHYSICIAN'S NAME (Type): Leonid V. Maldve, M. D.
Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan.6,1960
22c. NAME OF CEMETERY OR CREMATORY: Wicomico Mem.Park
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY - SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: JAN 5 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1321

Reg. Dist. No. 01321

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury, Maryland
c. LENGTH OF STAY IN 1b: 10 MO.22 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun, Maryland 07 x- 2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: David; Middle: Earl; Last: Nesbitt

4. DATE OF DEATH: Month: Jan; Day: 31; Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: March 16, 1894

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: unk

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles T. Nesbitt

14. MOTHER'S MAIDEN NAME: Ida E. Winchester

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES ~~unk~~ (If yes, give war or dates of service): W.W.I

16. SOCIAL SECURITY NO.: unk

INFORMANT: Hospital Records — Address: Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: --
DUE TO (b): Arteriosclerotic generalized — years
DUE TO (c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/9/59, 19__, to 1/31, 1960, that I last saw the deceased alive on Jan 31, 1960, and that death occurred at 12:40P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. Maldve, M.D. — ADDRESS (Street, city or town, state): Salisbury, Maryland — DATE SIGNED: 1/31/60

PHYSICIAN'S NAME (Type): L. Maldve, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-3-60

22c. NAME OF CEMETERY OR CREMATORY: Hopewell Methodist Cem.

22d. LOCATION (City, town, or county) (State): Rising Sun, R.D. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph P. Grant — ADDRESS: North East Md

24a. REC'D BY REGISTRAR DATE: FEB 4 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01322

Item 7 Film G255 1/27/60 iwk

Reg. Dist. No. 1322

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia — b. COUNTY: Accomac
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chincoteague 83 x 3
d. STREET ADDRESS: 307 Church St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

082

3. NAME OF DECEASED (Type or print): First: Olivia — Middle: E — Last: Northam
4. DATE OF DEATH: Month: 1-4-60 — Day — Year: 19

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 7, 1883
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Northam
14. MOTHER'S MAIDEN NAME: Elizabeth Northam

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Elizabeth Foxwell, Chincoteague, Va.

1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Broncho-pneumonia — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO
332X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Encephalomalacia — weeks
DUE TO
(c)

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture Rt. Hip — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell at home
20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year: 11 15 1959
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town) Chincoteague (County) Accomac (State) Va

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

2

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 1-12-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan. 7, 1960
22c. NAME OF CEMETERY OR CREMATORY: Downing Cemetery
22d. LOCATION (City, town, or county) (State): Oak Hall, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: William B. Selyer — ADDRESS: Chincoteague, Va.
24a. REC'D BY REGISTRAR — DATE: JAN 20 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kane

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1323 CERTIFICATE OF DEATH

Reg. Dist. No. 01323

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parsonsburg
d. STREET ADDRESS: Box 1135 (Salisbury)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harold — Middle: JOHN — Last: Oswald

4. DATE OF DEATH: Month: January — Day: 16 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 12, 1901

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinest -Employee-
10b. KIND OF BUSINESS OR INDUSTRY: Fish Products
11. BIRTHPLACE (State or foreign country): Brooklyn N.Y.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Harry Oswald
14. MOTHER'S MAIDEN NAME: Addie Volland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): W.W.#
16. SOCIAL SECURITY NO.:
INFORMANT: Mrs. Esther Oswald (Wife) Address: Parsonsburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Artery Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 - 2 yr
420.1
DUE TO (b): Coronary Atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Rheumatic Heart Disease (Mitral Stenosis)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from — 19 52 to date 19 ___, that I last saw the deceased alive on 1/16/, 19 60, and that death occurred at 5 P. M., from the causes and on the date stated above.
ACTUAL SIGNATURE: David J Gilmore M.D.
ADDRESS (Street, city or town, state): Salisbury Md
DATE SIGNED: 1/16/60
PHYSICIAN'S NAME (Type): David J. Gilmore
Medical Center Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan. 19, 1960
22c. NAME OF CEMETERY OR CREMATORY: Springhill Memory Gardens
22d. LOCATION (City, town, or county) (State): R.D.# Salisbury, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND
24a. REC'D BY REGISTRAR DATE: JAN 21 '60
24b. REGISTRAR'S SIGNATURE: Clifton L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1324 CERTIFICATE OF DEATH

Reg. Dist. No. 01324

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 109 W. Vine St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 1 109 W. Vine St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BERTIE — Middle ELLEN — Last PARSONS

4. DATE OF DEATH: Month JANUARY — Day 29th — Year 19 60

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 8,1875
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Wicomico Co. Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Dewitt J. Pryor
14. MOTHER'S MAIDEN NAME: Josephine Staton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
INFORMANT: Mr. Milton Parsons (Son) Address: 109 W. Vine St Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebro Vascular accident — INTERVAL BETWEEN ONSET AND DEATH
331x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Senility
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/2/58, 19____, to 1/30/60, 19____, that I lost saw the deceased alive on 1/29/60, 19____, and that death occurred at 11:30 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A. C. Mitchell M.D. — ADDRESS (Street, city or town, state): Salisbury, Md, — DATE SIGNED: ~~Jan.~~ 2/1/1960
PHYSICIAN'S NAME (Type): Dr. Andrew C. Mitchell
Dr. O. J. Burton — Maryland Ave Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 1, 1960
22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND
24a. REC'D BY REGISTRAR DATE: FEB 3 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG255 2-8-60 et

01325

1325

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 310 Ellegood St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury

d. STREET ADDRESS: 310 Ellegood St

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NORA — Middle LEAH — Last PARSONS

4. DATE OF DEATH: Month JANUARY — Day 30th — Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 5, 1874 (1874)

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months 6 — Days 25 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Shad Point(Wico.Co.)Md. U S A

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William McGrath

14. MOTHER'S MAIDEN NAME: Elizabeth Stewart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Mrs. Esther P. Hillman (Daughter) Address: 310 Ellegood St Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks.

DUE TO (b): atherosclerotic cardiovascular disease — 443X — Years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Essential Hypertension — Years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): L-popliteal artery thrombosis. Dehydration.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19__ to 1/30, 1960, that I last saw the deceased alive on 1/30, 1960, and that death occurred at 3:45 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: O. J. Burton M.D. — ADDRESS (Street, city or town, state): Maryland Ave, Salisbury, Maryland — DATE SIGNED: January /1960

PHYSICIAN'S NAME (Type): Dr. O. J. Burton

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Feb. 2, 1960 — 22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery — 22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: FEB 2 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01326

1325 Item 8 FilmG255 2-8-60 et

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Spring Hill Private Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 1022 Riverside Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle ELISHA Last PARSONS

4. DATE OF DEATH: Month JANUARY Day 27th Year 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 19, 1889

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Auto Mechanic-Garage

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): R.D.#Salisbury, Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Banjamin Parsons

14. MOTHER'S MAIDEN NAME: Melissia Savage

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Mrs Grace B. Parsons (Wife) Address: 1022 Riverside Drive Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 1 Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 22 days
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c) Arteriosclerotic Cardiovascular Disease 7

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus, Severe. — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/23, 19 59, to 1/27, 19 60, that I last saw the deceased alive on 1/29, 19 60, and that death occurred at 2:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Rufus S. Gardner Jr M.D.
ADDRESS (Street, city or town, state): Pine Bluff Road Salisbury, Maryland
DATE SIGNED: Jan. 29 /1960

PHYSICIAN'S NAME (Type): Dr. Rufus S. Gardner

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan. 29, 1960
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY
ADDRESS: SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: FEB 1 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1345 **CERTIFICATE OF DEATH** Reg. Dist. No. 01327

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R.F.D. 2 Quantico
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Home R.F.D. 2 Quantico Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R.F.D. 2 Quantico
d. STREET ADDRESS: R.F.D. 2 Quantico Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Paulette Middle R. Last Price

4. DATE OF DEATH: Month January Day 3 Year 1960

5. SEX: female

6. COLOR OR RACE: Col.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 22, 1959

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months 7 Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Levin Turner

14. MOTHER'S MAIDEN NAME: Helen Price

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Helen Price, R.F.D. 2 Quantico Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Interstitial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO:
525 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2 Jan., 1960 to 5 Jan., 1960 that I last saw the deceased alive on 5 Jan., 1960, and that death occurred at 1:30 a. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: E A Purnell M.D. ADDRESS (Street, city or town, state): 637 Main St Salisbury, Md. DATE SIGNED: 6 Jan 60

PHYSICIAN'S NAME (Type): E A PURNELL, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: Jan. 5, 1960

22c. NAME OF CEMETERY OR CREMATORY: Church Cemetery

22d. LOCATION (City, town, or county) (State): Quantico Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Clinton F. Stewart, Salisbury Md

24a. REC'D BY REGISTRAR DATE: JAN 7 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

2082234XU4

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG256 2-17-60 et

01328

1327 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 564 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

091

3. NAME OF DECEASED (Type or print): First: Arthur; Middle: ; Last: Roberts

4. DATE OF DEATH: Month: January; Day: 29; Year: 1960

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/26/1900

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months; Days; Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: -

14. MOTHER'S MAIDEN NAME: -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Address: Deer's Head Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Recurrent cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(b): Arteriosclerosis, general — Years
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.

332 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 15, 1958, to Jan. 29, 1960 that I last saw the deceased alive on January 29, 1960, and that death occurred at 11:20 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. V. Maldve M.D.
ADDRESS (Street, city or town, state): Deer's Head State Hospital
DATE SIGNED: 1/30/60

PHYSICIAN'S NAME (Type): L. V. Maldve, M. D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-4-60
22c. NAME OF CEMETERY OR CREMATORY: Cokesbury
22d. LOCATION (City, town, or county) (State): Cokesbury Md

23. FUNERAL DIRECTOR'S SIGNATURE: Baker Mervet
ADDRESS:

24a. REC'D BY REGISTRAR DATE: FEB 9 '60
24b. REGISTRAR'S SIGNATURE: Clifton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1328 CERTIFICATE OF DEATH

Reg. Dist. No. 01329

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 15 yrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: None

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: West Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Thurman Middle Savage Last
4. DATE OF DEATH: Month / Day 22 Year 1960

5. SEX: Male
6. COLOR OR RACE: Col
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 6-1911
9. AGE (In years last birthday): 48 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ?
INFORMANT: ~~EA~~ Thurman Savage Jr.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Unresolved pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO
493 X
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 15, 1960, to Jan 22, 1960 that I last saw the deceased alive an Jan 7th 1960, and that death occurred at 10:4 M, from the causes and on the date stated above.
ACTUAL SIGNATURE: L V Sohler M.D.
ADDRESS (Street, city or town, state): 302 East Dr Delmar
DATE SIGNED: 1-25-60
PHYSICIAN'S NAME (Type): L.V. Sohler

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-30-60
22c. NAME OF CEMETERY OR CREMATORY: Stockton Cem
22d. LOCATION (City, town, or county): Stockton (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Parker McWest
ADDRESS
24a. REC'D BY REGISTRAR DATE: JAN 27 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1329 — Reg. Dist. No. 01330

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 27 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: 209 W. Market
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

23 X - 2

3. NAME OF DECEASED (Type or print): First: Edward — Middle: M. — Last: Shockley

4. DATE OF DEATH: Month: January — Day: 10 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 16 - 1902

9. AGE (In years last birthday): 57 10/12 yrs

IF UNDER 1 YEAR — Months: — Days: — IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): City Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Snow Hill, Md

11. BIRTHPLACE (State or foreign country): Crisfield, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward M. Shackley

14. MOTHER'S MAIDEN NAME: Anna Mae Riggin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 579-03-8455

INFORMANT (Address): Mrs Julia H. Shockley, Snow Hill, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Lymphocytic Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 3 months
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

2043

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 14, 1959, to Jan 10, 1960, that I last saw the deceased alive on Jan 4, 1960, and that death occurred at 9 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas C. Hill, Jr. M.D.
ADDRESS (Street, city or town, state): Pine Bluff Road, Salisbury, Md
DATE SIGNED: 1/10/60
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan 13/60
22c. NAME OF CEMETERY OR CREMATORY: Presbyterian Cemetery
22d. LOCATION (City, town, or county) (State): Snow Hill Md

23. FUNERAL DIRECTOR'S SIGNATURE: Elmer E. Dennis
ADDRESS: Snow Hill, Md

24a. REC'D BY REGISTRAR DATE: JAN 13 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1346 CERTIFICATE OF DEATH

Reg. Dist. No. 01331

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 40 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: RFD # 2

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Salisbury
d. STREET ADDRESS: RFD # 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gertrude — Middle: Margaret — Last: Shockley

4. DATE OF DEATH: Month: Jan. — Day: 21, — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-17-1909

9. AGE (In years lost birthday): 50 yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS.: Months | Days | Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Salisbury, Md

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: DeWitt Rounds

14. MOTHER'S MAIDEN NAME: Laura Bridell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -------

16. SOCIAL SECURITY NO.: None

INFORMANT / Address: Jas. George Shockley, Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 5 min
DUE TO
331X
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b): hypertension, essential, severe. 10 years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19 54, to Jan 21, 1960, that I last saw the deceased alive on October, 1959, and that death occurred at 8:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L. V. Sohler M.D.
ADDRESS (Street, city or town, state): 303 East St. Delmar Md.
DATE SIGNED: Jan 23, 60
PHYSICIAN'S NAME (Type): L. V. Sohler

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-25-60
22c. NAME OF CEMETERY OR CREMATORY: M.E.
22d. LOCATION (City, town, or county) (State): Delmar, Del.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: W. A. Mandl Co Delmar, Del

24a. REC'D BY REGISTRAR DATE: JAN 25 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01332

1330

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carey Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: Carey Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET Middle ELIZABETH Last SHORT
4. DATE OF DEATH: Month JANUARY Day 2nd Year 1960

5. SEX: Fenale
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 9,1871
9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months 9 Days 22
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home
10b. KIND OF BUSINESS OR INDUSTRY: Retired-None
11. BIRTHPLACE (State or foreign country): Sussex Co. Delaware
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Levin Esham
14. MOTHER'S MAIDEN NAME: Mahala Hall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT (Address): Mrs. Henry Phillips (Daughter) Carey Ave. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b): Hypertension & V. Disease — June

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Dr. Earl L. Royer
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: January 4 /1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan. 5, 1960
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND
24a. REC'D BY REGISTRAR DATE: JAN 6 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01333

1331 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE New York — b. COUNTY Queens Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jamaica 35 69x-3
d. STREET ADDRESS 143-11 84 Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First HETTIE Middle ISABELLA Last Sizemore

4. DATE OF DEATH Month January Day 6 Year 1960

5. SEX Female — 6. COLOR OR RACE White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH Nov. 15, 1876

9. AGE (In years last birthday) 83 yrs. — IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work - Retired
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Oxford North Carolina
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Robert Elliott
14. MOTHER'S MAIDEN NAME Sarah Rebecca Hunt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT Mrs. Lillian Lloyd (Daughter) Address 143-11 84th Road Jamaica 35, New York

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH Months
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-31, 1959, to 1-6, 1960, that I last saw the deceased alive on 1-6, 1960, and that death occurred at 9:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Wilber R. Ellis M.D. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 1-6-60

PHYSICIAN'S NAME (Type) Dr. Wilber R. Ellis Medical Center Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Jan. 11 /60
22c. NAME OF CEMETERY OR CREMATORY Maple Grove Cemetery-Queens "Q" Gardens N.Y.
22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND
24a. REC'D BY REGISTRAR DATE JAN 11 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1332 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01334

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Salisbury
f. STREET ADDRESS: Route # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: HILARY — Middle: NELSON — Last: SMITH

4. DATE OF DEATH: Month: 1-23-60 — Day — Year: 19

5. SEX: M — 6. COLOR OR RACE: W — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: Feb.2,1924 — 9. AGE (In years last birthday): 35 yrs. — IF UNDER 1 YEAR: Months 11, Days 21 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sander-Employee of Chris-Craft Corp
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): R.D.# Salisbury, Md
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Wilmer J. Smith
14. MOTHER'S MAIDEN NAME: Agnes Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Raymond J. Smith (Brother) Address: Lakeview Dr. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Crushed Chest — INTERVAL BETWEEN ONSET AND DEATH: 4 days
816X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Driver of car involved in a collision.
20c. TIME OF INJURY: Hour o. m.: 7 P.M. — Month, Day, Year: 1-14-60
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Pine Bluff Rd.
20f. (City or town): Salisbury (County): Wicomico (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 1-25-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan.26/1960
22c. NAME OF CEMETERY OR CREMATORY: St John's Cemetery
22d. LOCATION (City, town, or county) (State): Fruitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND
24a. REC'D BY REGISTRAR DATE: JAN 29 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1333 **CERTIFICATE OF DEATH** Reg. Dist. No. 01335

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 Hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 314 Park Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LOUIS Middle FRANCIS Last STEVENS

4. DATE OF DEATH: Month 1 Day 28 Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 26, 1896
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager
10b. KIND OF BUSINESS OR INDUSTRY: Bowling Alley
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert J. Stevens
14. MOTHER'S MAIDEN NAME: Rebecca Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W.I
16. SOCIAL SECURITY NO.: 213-12-5287
17. INFORMANT: Mrs. L.F. Stevens, Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b): Angina — 4 Days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 1958 to 1-28, 1960, that I last saw the deceased alive on 1-28, 1960, and that death occurred at 5:15A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Andrew C Mitchell M.D. ADDRESS (Street, city or town, state): Salisbury, Maryland DATE SIGNED: 1-28-60

PHYSICIAN'S NAME (Type): Dr. A.C. Mitchell 211 Maryland Ave., Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-30-1960
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or county) (State): Salisbury, MAryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hill & Johnson Co. Salisbury MAryland
Norman T. Baker
24a. REC'D BY REGISTRAR DATE: FEB 1 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01336

1336

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 54 YRS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 306 Maryland
d. STREET ADDRESS: 306 Maryland Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELLA Middle Hoblitzell Last Taylor
4. DATE OF DEATH: Month 1 Day 3 Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 20, 1870
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jerimiah Hoblitzell
14. MOTHER'S MAIDEN NAME: Julia Daugherty

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Address: Mr. James Taylor, Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
331X
DUE TO
(b) Arteriosclerosis.
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 1955, to Jan 3, 1960, that I last saw the deceased alive on Jan 2, 1960, and that death occurred at 2 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Carrie I. Hearn M.D. ADDRESS (Street, city or town, state): 226 N. Division St. Salisbury, Md. DATE SIGNED: 1/4/60

PHYSICIAN'S NAME (Type): Dr. Carrie I. Hearn 226 N. Division St., Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-5-60
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hill & Johnson Co. Salisbury, Maryland
24a. REC'D BY REGISTRAR DATE: JAN 6 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Nicholas Theodore

CERTIFICATE OF DEATH

Reg. Dist. No. 01337

1335

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Salisbury (Rural)
d. STREET ADDRESS: R.D.# 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Nicholas; Middle:; Last: Theodore

4. DATE OF DEATH: Month: January; Day: 27; Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: June 20, 1885

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (State or foreign country): Bulgaria

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: No Record

14. MOTHER'S MAIDEN NAME: No Record

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

INFORMANT: Mr Ota J. Stevenson (Friend) Address: Meadow Bridge Rd. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 48 hours.
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ARTERIOSCLEROTIC Heart disease — 4 yrs
DUE TO
(c) generalized arteriosclerosis — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December, 1959, to January 27 1960 that I last saw the deceased alive on January 27, 1960, and that death occurred at 5 00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert T. Adkins M.D. ADDRESS (Street, city or town, state): FRUITLAND, MARYLAND DATE SIGNED: 27 Jan. 60

PHYSICIAN'S NAME (Type): Dr. Robert Adkins — Fruitland Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan. 30, 1960
22c. NAME OF CEMETERY OR CREMATORY: Wicomico Mem Park
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: FEB 1 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filed in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01338

1336 # CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY: Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury, Md.

LENGTH OF STAY (In this place): since 12/28/59

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Pine Bluff State Hospital Salisbury, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland COUNTY: Wicomico

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

STREET ADDRESS (If rural give location): RFD #3

3. NAME OF DECEASED (Type or Print): (First) Murray (Middle) Eugene (Last) Walston

4. DATE OF DEATH: (Month) Jan. (Day) 11 (Year) 1960

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
Male	White	Married	Aug. 14, 1914	45 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer		Salisbury, Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Murray C. Walston	Minnie Farlow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S ADDRESS
No	218-12-1395	Mrs. E. Elizabeth Walston (Wife) City Records of Pine Bluff State Hospital

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
434.11 IMMEDIATE CAUSE (A)	Cor. Pulmonale	4 wks.
ANTECEDENT CAUSE(S) DUE TO (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 002 X	Pulmonary Tuberculosis	3 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 28, 19 59, to Jan. 10, 19 60, that I last saw the deceased alive on Jan. 10, 19 60, and that death occurred at 2:53a M, from the causes and on the date stated above.

SIGNATURE	ADDRESS (Street, city, town, state)	DATE SIGNED
Edward P. Ritchings M.D.	Salisbury, Maryland	Jan. 11, 1960

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 13/60	Parsons Cemetery	Salisbury, Maryland

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
JAN 15 '60	Clifton S. Krauss	HOLLOWAY & COMPANY-SALISBURY, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1337 — 01339 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 5 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 082 Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill Rural #1
d. STREET ADDRESS: 23X 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Lena — Middle: M. — Last: Ward

4. DATE OF DEATH: Month: January — Day: 14 — Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 22 — 1890
9. AGE (In years last birthday): 69 Yrs. 23 Ds.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Castleville Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Mears
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 207-16-9431
INFORMANT: Mrs. Annie Mygang — Address: Snow Hill, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Bronchitis and Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Pulmonary Fibrosis and Emphasema
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 502.0
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 10, 1960, to Jan 14, 1960 that I last saw the deceased alive on Jan 14, 1960, and that death occurred at 4.45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas C. Hill Jr. M.D. — ADDRESS (Street, city or town, state): Pine Bluff Road Salisbury Md — DATE SIGNED: 1/15/60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Jan 17/60 — 22c. NAME OF CEMETERY OR CREMATORY: Bates Methodist — 22d. LOCATION (City, town, or county) (State): Snow Hill Md

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. E. Timmis — ADDRESS: Snow Hill, Md

24a. REC'D BY REGISTRAR DATE: JAN 18 '60 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1347

01340

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: 400 Pine Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY: Allegheny
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest town): Pittsburgh 75 x-3
d. STREET ADDRESS: 3854 Baytree Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Wilhemia; Middle: Minnie H.; Last: Weinert

4. DATE OF DEATH: Month: Jan. 11; Day; Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Mar 2,1886

9. AGE (In years lost birthday): 73 yrs.
IF UNDER 1 YEAR: Months; Doys
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (Stote or foreign country): Pittsburgh

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Weisner

14. MOTHER'S MAIDEN NAME: Elizabeth Keil

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

INFORMANT: Mary Mullin, Delmar, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), ond (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 5 min.
420.1
DUE TO
(b): Myocardial infarct, posterior. — 3 days
Conditions, if ony, which gave rise to immediate couse (o), stoting the underlying couse lost.
DUE TO
(c): Coronary arty arteriosclerosis — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): Hypertension

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While ot work ☐ Not while ot work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. I **certify** that I attended the deceased from 1/1, 1960, to death, 19___, that I last saw the deceased alive on Jan 11, 1960, and that death occurred at 1 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Ernest M. Farmer M.D.
ADDRESS (Street, city or town, stote): Delmar, Del
DATE SIGNED: 1/12/60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-15-60
22c. NAME OF CEMETERY OR CREMATORY: United
22d. LOCATION (City, town, or county) (Stote): Pittsburgh, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: W. S. Mantel Co-Delmar, Del

24a. REC'D BY REGISTRAR DATE: JAN 14 '60
24b. REGISTRAR'S SIGNATURE: Cirthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registror priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

1338

CERTIFICATE OF DEATH

Reg. Dist. No. 01341

1. PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b ✓
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md — b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill 23x-2
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Baby — Middle — Last Wharton

4. DATE OF DEATH Month January — Day 11 — Year 1960

5. SEX Male

6. COLOR OR RACE Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH January 11, 1960

9. AGE (In years last birthday) - yrs. — IF UNDER 1 YEAR: Months - Days - IF UNDER 24 HRS.: Hours 1 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Salisbury Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Raymond L. Jackson

14. MOTHER'S MAIDEN NAME Edna Wharton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

INFORMANT Raymond L. Jackson Address Snow Hill Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congenital anomalies - multiple
759.3
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4:00 P.M. - 1-11, 1960, to 5:30 P.M. - 11, 1960, that I last saw the deceased alive on 1-11-, 1960, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Stedman W. Smith M.D.

ADDRESS (Street, city or town, state) Salisbury, Md.

DATE SIGNED

PHYSICIAN'S NAME (Type) Stedman W. Smith

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Jan. 13/60

22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery

22d. LOCATION (City, town, or county) Pocomoke (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Ellery E. Timmis ADDRESS Snow Hill Md

24a. REC'D BY REGISTRAR DATE JAN 13 '60

24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

20219 2XV4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1339 — Reg. Dist. No. 01342

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Quantico
d. STREET ADDRESS: RFD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David — Middle: — Last: Wilson

4. DATE OF DEATH: Month: 1 — Day: 25 — Year: 1960

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3 Dsept 1900

9. AGE (In years last birthday): 59 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sawyer

10b. KIND OF BUSINESS OR INDUSTRY: Saw Mill

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Wilson

14. MOTHER'S MAIDEN NAME: Hettie Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT — Address: Hettie Wilson, Quantico, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Broncho pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Fractured left femur hemothorax — 10 days
DUE TO (c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

900.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell down steps, slipped on ice

20c. TIME OF INJURY: Hour 7:30 (a. m. / p. m.) — Month, Day, Year: 1 15 1960

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Quantico Wicomico Md

21. I certify that I take charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L Roger M.D.
EXAMINER'S NAME (Type): Earl L. Roger
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 1-26-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/31/60
22c. NAME OF CEMETERY OR CREMATORY: Md. of Creek Cem.
22d. LOCATION (City, town, or county) (State): Quantico, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C. M. Jessub — ADDRESS: Bivalve, Md.

24a. REC'D BY REGISTRAR DATE: FEB 1 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kenney

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate omitting the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1347 — Reg. Dist. No. 01343

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tyaskin RFD
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x / Tyaskin
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Henry — Middle: — Last: Wilson

4. DATE OF DEATH: Month: i — Day: 19 — Year: 196-

5. SEX: M — 6. COLOR OR RACE: C — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 8-15-85 — 9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer — 10b. KIND OF BUSINESS OR INDUSTRY: Farm — 11. BIRTHPLACE (State or foreign country): Tyaskin — 12. CITIZEN OF WHAT COUNTRY?: Native

13. FATHER'S NAME: Benjamin Wilson — 14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): — 16. SOCIAL SECURITY NO.: — — 17. INFORMANT: Octavia Wilson — Address: Tyaskin RFD, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.0
DUE TO (b): Arterio-Sclerotic Heart Dis. — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L. Roger M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 1-20-60

EXAMINER'S NAME (Type): Earl L. Roger

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 1/23/60 — 22c. NAME OF CEMETERY OR CREMATORY: White Haven Cem. — 22d. LOCATION (City, town, or county) (State): Tyaskin, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C. M. Mason — ADDRESS: Bivalve, Maryland — 24a. REC'D BY REGISTRAR DATE: JAN 22 '60 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Tirard

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1340 CERTIFICATE OF DEATH

Reg. Dist. No. 01344

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 24 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Hebron

3. NAME OF DECEASED (Type or print): First: ISAAC — Middle: Thomas — Last: Wimbrow

4. DATE OF DEATH: Month: January — Day: 25 — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 11, 1876

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Dairyman

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Wimbrow

14. MOTHER'S MAIDEN NAME: Letitia Cooper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.:

INFORMANT: Mrs. Ruth Gaffard — Address: Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 25 days
420.1
DUE TO
(b): Arteriosclerotic Cardiovascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Jan 1, 1960, to Jan 25, 1960, that I last saw the deceased alive on Jan 25, 1960, and that death occurred at 10:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas C. Hill Jr. M.D.
ADDRESS (Street, city or town, state): Pine Bluff Road Salisbury, Md
DATE SIGNED: 1/25/60
PHYSICIAN'S NAME (Type): Thomas C. Hill, Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-28-1960
22c. NAME OF CEMETERY OR CREMATORY: Hebron Cemetery
22d. LOCATION (City, town, or county) (State): Hebron, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Hill & Johnson Co
ADDRESS: Salisbury, Md

24a. REC'D BY REGISTRAR DATE: JAN 27 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58